		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003103

Facility Name: Memorial Convalescent Center

Address: 4315 Memorial Drive (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: (618)233-7750 **Fax #** (618)257-6839

IDPA ID Number: 37-0635502-002

Date of Initial License for Current Owners: 03/01/1964

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Valorie Comley **Telephone Number:** (618)257-5613

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 4/29/2005 (Date)
(Type or Print Name) Joe Lanius
(Title) Vice President - Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,108		23,542	27,650	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,108		23,542	27,650	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.95%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/03/1964

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 108 and days of care provided 11,854

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	438,795	2,400		441,195		441,195	242,841	684,036			1
2	Food Purchase		307,756		307,756		307,756		307,756			2
3	Housekeeping	87,563	7,585		95,148		95,148	41,781	136,929			3
4	Laundry		77,821		77,821		77,821	45,469	123,290			4
5	Heat and Other Utilities			72,575	72,575	(2,073)	70,502		70,502			5
6	Maintenance	51,307	7,636		58,943		58,943	11,853	70,796			6
7	Other (specify):*											7
8	**TOTAL General Services**	577,665	403,198	72,575	1,053,438	(2,073)	1,051,365	341,944	1,393,309			8
	B. Health Care and Programs											
9	Medical Director					13,370	13,370		13,370			9
10	Nursing and Medical Records	2,503,478	158,866	16,235	2,678,579	497	2,679,076	61,812	2,740,888			10
10a	Therapy	496,978	21,043		518,021		518,021	240,956	758,977			10a
11	Activities	81,141	4,453		85,594		85,594		85,594			11
12	Social Services	65,435			65,435		65,435	92,108	157,543			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Disposable Diapers**		76,582		76,582	(16,269)	60,313	(20,705)	39,608			15
16	**TOTAL Health Care and Programs**	3,147,032	260,944	16,235	3,424,211	(2,402)	3,421,809	374,171	3,795,980			16
	C. General Administration											
17	Administrative	81,761			81,761	(13,370)	68,391		68,391			17
18	Directors Fees											18
19	Professional Services			41,780	41,780		41,780		41,780			19
20	Dues, Fees, Subscriptions & Promotions			5,640	5,640		5,640		5,640			20
21	Clerical & General Office Expenses	53,417		10,215	63,632	456	64,088	145,035	209,123			21
22	Employee Benefits & Payroll Taxes			680,634	680,634		680,634	216,205	896,839			22
23	Inservice Training & Education											23
24	Travel and Seminar			110	110		110		110			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			49,887	49,887		49,887		49,887			26
27	Other (specify):* **Bad Debts**			51,277	51,277		51,277	(51,277)				27
28	**TOTAL General Administration**	135,178		839,543	974,721	(12,914)	961,807	309,963	1,271,770			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,859,875	664,142	928,353	5,452,370	(17,389)	5,434,981	1,026,078	6,461,059			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Memorial Convalescent Center #0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			141,221	141,221		141,221	95,474	236,695			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					16,269	16,269		16,269			35
36	Other (specify):* **Loss on Disposal**			986	986		986		986			36
37	**TOTAL Ownership**			142,207	142,207	16,269	158,476	95,474	253,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	72,734	362,674		435,408		435,408	35,862	471,270			39
40	Barber and Beauty Shops					1,120	1,120		1,120			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,292	59,292		59,292		59,292			42
43	Other (specify):*	55,552	39,688	10,065	105,305		105,305	45,602	150,907			43
44	**TOTAL Special Cost Centers**	128,286	402,362	69,357	600,005	1,120	601,125	81,464	682,589			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,988,161	1,066,504	1,139,917	6,194,582		6,194,582	1,203,016	7,397,598			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,606)	30		9
10	Interest and Other Investment Income	(1)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,277)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,884)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,262,900		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,262,900		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,203,016		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops			1,120	40	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,120		47

STATE OF ILLINOIS

Memorial Convalescent Center

ID# 0003103

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	242,841	0	0	0	0	0	0	0	0	0	242,841	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	41,781	0	0	0	0	0	0	0	0	0	41,781	3
4	Laundry	0	45,469	0	0	0	0	0	0	0	0	0	45,469	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	11,853	0	0	0	0	0	0	0	0	0	11,853	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	341,944	0	0	0	0	0	0	0	0	0	341,944	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	61,812	0	0	0	0	0	0	0	0	0	61,812	10
10a	Therapy	0	240,956	0	0	0	0	0	0	0	0	0	240,956	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	92,108	0	0	0	0	0	0	0	0	0	92,108	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(20,705)	0	0	0	0	0	0	0	0	0	(20,705)	15
16	**TOTAL Health Care and Programs**	0	374,171	0	0	0	0	0	0	0	0	0	374,171	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1)	145,036	0	0	0	0	0	0	0	0	0	145,035	21
22	Employee Benefits & Payroll Taxes	0	216,205	0	0	0	0	0	0	0	0	0	216,205	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(51,277)	0	0	0	0	0	0	0	0	0	0	(51,277)	27
28	**TOTAL General Administration**	(51,278)	361,241	0	0	0	0	0	0	0	0	0	309,963	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,278)	1,077,356	0	0	0	0	0	0	0	0	0	1,026,078	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Memorial Convalescent Center** **#** **0003103** **Report Period Beginning:** **01/01/2004** **Ending:** **12/31/2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,606)	104,080	0	0	0	0	0	0	0	0	0	95,474	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,606)	104,080	0	0	0	0	0	0	0	0	0	95,474	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	35,862	0	0	0	0	0	0	0	0	0	35,862	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	45,602	0	0	0	0	0	0	0	0	0	45,602	43
44	**TOTAL Special Cost Centers**	0	81,464	0	0	0	0	0	0	0	0	0	81,464	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(59,884)	1,262,900	0	0	0	0	0	0	0	0	0	1,203,016	45

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Employee Benefits	$ 680,634	Memorial Hospital	0.00%	$ 896,839	$ 216,205	1
2	V	21	Administration	64,089			209,125	145,036	2
3	V	6	Maintenance	58,944			70,797	11,853	3
4	V	4	Laundry	77,821			123,290	45,469	4
5	V	3	Housekeeping	95,148			136,929	41,781	5
6	V	1	Dietary	441,195			684,036	242,841	6
7	V	15	Central	60,313			39,608	(20,705)	7
8	V	39	Pharmacy,Medical Supplies	435,408			471,270	35,862	8
9	V	43	Ancillary Services	105,304			150,906	45,602	9
10	V	12	Social Service	65,435			157,543	92,108	10
11	V	10	Medical Records	1,617			63,429	61,812	11
12	V	10a	Therapy	518,022			758,978	240,956	12
13	V	30	Depreciation	142,207			246,287	104,080	13
14	Total			$ 2,746,137			$ 4,009,037	$ * 1,262,900	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Emp Ben-Nursing & Med Dir	Salaries	71,547,502	2	$ 23,890,953	$ 582,940	2,519,052	$ 841,155	1
2	21	Patient Accounts	Revenue	348,815,570	2	2,561,510	1,058,201	4,194,958	30,805	2
3	21	Communications	Phones	1,093	2	468,563	192,371	6	2,572	3
4	21	Data Processing	Resources	9,999	2	2,064,000	723,265	70	14,449	4
5	21	Materials Management	Stores Requisitions	5,416,042	2	654,523	412,241	111,554	13,481	5
6	21	Administration	Accumulated Cost	143,819,535	2	11,977,967	4,196,054	3,765,649	313,621	6
7	6	Plant	Square Feet	18,453	2	161,757	51,307	16,119	141,297	7
8	4	Laundry	Pounds	2,463,966	2	971,583	358,901	312,668	123,290	8
9	3	Housekeeping	Hours of Service	113,461	2	2,364,864	1,387,978	471	9,817	9
10	3	Housekeeping MCC	Square Feet	17,705	2	139,618	87,563	16,119	127,111	10
11	1	Dietary	Patient Meals	265,385	2	3,173,076	1,660,666	82,950	991,792	11
12	22	Emp Ben-Cafeteria	Employee Meals	147,539	2	1,058,300	428,067	7,763	55,684	12
13	10	Medical Records	Time Spent	10,000	2	3,731,073	1,930,149	170	63,428	13
14	12	Social Service	Time Spent	1,396,759	2	781,202	482,492	281,680	157,543	14
15	43	Radiology	Revenue	80,080,012	2	9,935,185	3,196,745	120,167	14,909	15
16	43	Laboratory	Revenue	61,443,126	2	12,474,841	3,996,924	525,164	106,624	16
17	43	Nutritional Support	Revenue	533,756	2	508,064	226,579	20,808	19,806	17
18	43	EKG	Revenue	14,723,134	2	2,706,441	916,077	52,044	9,567	18
19	39	Drugs & IV Therapy	Revenue	20,165,901	2	9,766,187	1,889,695	910,869	441,127	19
20	39	Medical Supplies Sold	Revenue	3,022,729	2	4,193,193	557,760	50,281	69,751	20
21	10a	Respiratory Care	Revenue	12,069,574	2	3,294,883	1,818,425	307,189	83,860	21
22	10a	Physical Therapy	Revenue	13,694,264	2	5,379,298	2,825,636	1,255,809	493,299	22
23	10a	Occupational Therapy	Revenue	1,460,353	2	459,966	274,936	564,696	177,862	23
24	10a	Speech Therapy	Revenue	166,019	2	110,025	63,262	5,971	3,957	24
25	TOTALS					$ 102,827,072	$ 29,318,234		$ 4,306,807	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Capital Costs	See Attached	11,281,925		$ 11,281,925	$	246,287	$ 246,287	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 11,281,925	$		$ 246,287	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2				Not Applicable								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0003103

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,001 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	$ 882,395	$ 8,260		$	$ (8,260)	$ 882,395	4
5			1966		144,150	452			(452)	144,150	5
6			1979		237,657	1,582	20.28	1,582		221,399	6
7			1980		2,695					2,695	7
8			1981		18,583					18,583	8
	Improvement Type**										
9	Electrical Upgrade			1996	25,549	1,359		1,359		11,555	9
10	Walking Track			1998	7,690	512	15	512		3,334	10
11	Roof Replacement			1998	68,383	6,838	10	6,838		44,448	11
12	Change in electical power system			1998	5,479	366	15	366		2,373	12
13	7 1/2 ton A/C Unit			1998	14,326	955	15	955		6,208	13
14	Air furnace			1998	15,226	1,015	15	1,015		6,598	14
15	5 ton air handler			1998	14,900	993	15	993		6,455	15
16	Electrical work-boiler rm, A/C unit, relamp, auto tr switch			1998	91,162	4,557	20	4,557		29,625	16
17	Air handling unit installed			1994	12,048	803	15	803		8,432	17
18	Repair parking lot			1994	83,569	2,785	10.85	2,785		68,575	18
19	Landscaping			1994	4,200	280	15	280		2,940	19
20	Flooring replaced patient room			1993	56,883	3,792	15	3,792		43,612	20
21	Activity Therapy Renovation			1993	41,940	2,262	12.83	2,262		31,068	21
22	Condensing unit			1993	4,684	312	15	312		3,590	22
23	Air conditioners			1993	6,589	440	15	440		5,051	23
24	Upgrade lighting			1993	4,516	226	20	226		2,599	24
25	Renovate patient room & nurse station			1992	42,370	2,322	17.99	2,322		29,350	25
26	Renovate patient rooms-doors, wallcovering,bldg			1992	75,908	719	10.49	719		74,104	26
27	Roof top air conditioner			1992	4,342	289	15	289		3,618	27
28	Renovate business office			1991	35,387	1,817	18.5	1,817		27,374	28
29	Patient rooms-drywall,ceiling, paint			1991	39,835	2,426	14.55	2,426		35,701	29
30	Demolish back lounge			1991	752	50	15	50		676	30
31	Brickwork chimney			1991	5,225	348	15	348		4,702	31
32	Paint exterior tower			1991	1,185		5			1,185	32
33	ITE panel			1991	995	50	20	50		673	33
34	Air conditioners			1991	6,580	438	15	438		5,922	34
35	Telephone wiring			1991	924		10			924	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Circuit Breaker	1991	$ 1,011	$ 51	20	$ 51	$	$ 683	37
38	Cubicles & track	1990	9,899		5			9,899	38
39	Half glass door windows	1989	601	20	15	20		601	39
40	Roofing	1988	55,463		10			55,463	40
41	Air Conditioner	1998	1,556		5			1,556	41
42	Air Conditioner	1987	1,551		5			1,551	42
43	Remove bathroom showers	1987	17,966	464	15.56	464		16,809	43
44	Cooling units	1986	3,854		9			3,854	44
45	Cooling units	1985	5,644		10			5,644	45
46	Resurface road	1985	39,780		12			39,780	46
47	Guttering	1985	2,116		15			2,116	47
48	Metal door frames	1984	5,751	144	20	144		5,750	48
49	Water & sewer lines	1984	2,807	70	20	70		2,807	49
50	Sprinkler system	1978	27,578		19			27,578	50
51	Sprinkler system	1977	1,585		20			1,585	51
52	Cooling unit & heat detectors	1974	5,468		17.99			5,468	52
53	Air conditioners & beauty shop	1973	1,210		14.94			1,210	53
54	Heating & cooling equipment	1972	53,944		15.22			53,944	54
55	Smoke detector	1971	5,800		10			5,800	55
56	Land improvements	1968	4,238		40	106	106	3,975	56
57	Vinyl flooring restrooms	1999	2,441	244	5	244		2,441	57
58	Reznor make up air unit	1999	15,432	1,543	10	1,543		8,487	58
59	Electrical work	1999	2,566	128	20	128		704	59
60	New door physical therapy	2000	3,735	249	15	249		1,121	60
61	Porch columns	2000	5,965	398	15	398		1,791	61
62	Repair walls	2001	2,080	139	15	139		486	62
63	Electrical work	2001	4,191	209	20	209		734	63
64	Electrical work	2001	16,778	839	20	839		2,936	64
65	Window replacement	2002	113,345	7,557	15	7,557		18,892	65
66	Storage addition	2002	253,195	16,879	15	16,879		42,201	66
67	Storage addition	2002	4,227	845	5	845		2,113	67
68	Storage addition	2002	1,259		1			1,259	68
69	Fire Alarm/Nurse Call Replacement	2002	4,473	299	15	299		747	69
70	TOTAL (lines 4 thru 69)		$ 2,633,636	$ 76,326		$ 67,720	$ (8,606)	$ 2,059,899	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,633,636	$ 76,326		$ 67,720	$ (8,606)	$ 2,059,899	1
2	Fire Alarm/Nurse Call Replacement	2002	350	117	3	117		292	2
3	Fire Alarm/Nurse Call Replacement	2002	1,001	200	5	200		500	3
4	Fire Alarm/Nurse Call Replacement	2002	48,125	4,812	10	4,812		12,031	4
5	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		82	5
6	Fire Alarm/Nurse Call Replacement	2002	61,775	3,089	20	3,089		7,720	6
7	Patient Wardrobe Units	2002	67,813	4,521	15	4,521		11,303	7
8	Patient Wardrobe Units	2002	5,824	582	10	582		1,455	8
9	Heating and Cooling Unit	2002	7,702	513	15	513		1,283	9
10	8" Faucets	2002	5,318	266	20	266		665	10
11	Window Replacement	2003	75	5	15	5		8	11
12	Storage Addition	2003	138	9	15	9		14	12
13	Fire Alarm/Nurse Call Replacement	2003	659	66	10	66		99	13
14	Window Replacement	2003	16,451	1,097	15	1,097		1,645	14
15	Patient Wardrobe Units	2003	16,789	839	20	839		1,259	15
16	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		1,481	16
17	Utility Storage Room Plumbing Work	2004	776	20	20	20		20	17
18	Beauty Shop/Utility Room Renovations	2004	4,626	116	20	116		116	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,891,293	$ 93,598		$ 84,992	$ (8,606)	$ 2,099,872	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 429,452	$ 37,994	$ 37,994	$		$ 253,920	71
72	Current Year Purchases	38,874	3,482	3,482		7.5	3,482	72
73	Fully Depreciated Assets	233,105					233,105	73
74								74
75	TOTALS	$ 701,431	$ 41,476	$ 41,476	$		$ 490,507	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	$ 49,174	$ 6,147	$ 6,147	$	4	$ 49,174	76
77										77
78										78
79										79
80	TOTALS			$ 49,174	$ 6,147	$ 6,147	$		$ 49,174	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,681,898	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 141,221	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,615	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,606)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,639,553	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 16,269 Description: See page 24
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$ 159,360		$	$ 4,901		$ 164,261	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	290,191			5,015		295,206	4
5	Physician Care	10	visits		8	1,506		8	1,506	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	72,734			362,674		435,408	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 522,285	8	$ 1,506	$ 372,590	8	$ 896,381	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 325	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	633,828		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,637		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due third-party payers	2,584		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 639,374	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,766,360		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	681,799		16
17	Accumulated Depreciation (book methods)	(2,577,971)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	152,289		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,062,477	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,701,851	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 139,747	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	154,943		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 294,690	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserves for Self Insurance	418,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 418,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 712,690	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 989,161	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,701,851	$	48

***(See instructions.)**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,315,878	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,315,878	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(50,214)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	14,310	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (35,904)	17
	B. Transfers (Itemize):		
18	**Interfund Transfer - Hospital**	(290,813)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (290,813)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 989,161	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,194,958	1
2	Discounts and Allowances for all Levels	(1,864,709)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,330,249	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,826,476	6
7	Oxygen	307,189	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,133,665	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,120	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	910,869	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	525,164	19
20	Radiology and X-Ray	120,167	20
21	Other Medical Services	123,133	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,680,453	23
	D. Non-Operating Revenue		
24	Contributions	14,310	24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,311	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,158,678	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,053,438	31
32	Health Care	3,424,211	32
33	General Administration	974,721	33
	B. Capital Expense		
34	Ownership	142,207	34
	C. Ancillary Expense		
35	Special Cost Centers	540,713	35
36	Provider Participation Fee	59,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,194,582	40
41	**Income before Income Taxes (line 30 minus line 40)****	(35,904)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (35,904)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	437	608	$ 21,721	$ 35.73	1
2	Assistant Director of Nursing	1,841	2,130	71,667	33.65	2
3	Registered Nurses	27,840	31,955	833,982	26.10	3
4	Licensed Practical Nurses	9,551	11,283	224,809	19.92	4
5	Nurse Aides & Orderlies	73,698	83,582	1,073,183	12.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,966	5,621	81,141	14.44	10
11	Social Service Workers	2,832	3,205	65,435	20.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,218	41,696	438,795	10.52	15
16	Dishwashers					16
17	Maintenance Workers	3,192	3,570	51,307	14.37	17
18	Housekeepers	7,925	8,978	87,563	9.75	18
19	Laundry					19
20	Administrator	1,126	1,567	54,860	35.01	20
21	Assistant Administrator	223	253	13,531	53.48	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,601	16,302	329,915	20.24	24
25	Vocational Instruction	6,460	7,477	159,360	21.31	25
26	Academic Instruction					26
27	Medical Director	93	106	13,370	126.13	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	106	119	1,617	13.59	31
32	Other Health Care(specify)	20,435	23,334	465,905	19.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,544	241,786	$ 3,988,161 *	$ 16.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		3,333	Ln 10 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Physician Advisor	61	7,200	Ln 10 Col 3	46
47	Physician Reviewer		4,196	Ln 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)	61	$ 14,729		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	485	$ 25,140	Ln 10 Col 1	50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,129	55,414	Ln 10 Col 1	52
53	TOTAL (lines 50 - 52)	3,614	$ 80,554		53

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Mary Ann Hagler	Admin Assist		54,860
Joe Lanius	VP - Finance		7,442
Terry Walther	VP - Rehab		6,089
Dr. William Sutherland	Medical Director		13,370
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,761

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
B.K.D., LLP	Audit Fees	$ 4,300
Bell, Boyd & Lloyd, PLLC	Attorney Fees	37,480
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,780

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care	5,540
American Assoc of Nurse	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,640

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
New Enforcement of Subpart S	110
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 110

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Health Care $5,540**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,608** Line **15**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **55,684** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,106,612**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.